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Statistical Bulletin

METROPOLITAN LIFE INSURANCE COMPANY

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Health Conditions in Europe

DESPITE the devastation wrought by World War II and the resulting depression of living standards, relatively favorable mortality conditions prevail among many European peoples. Western Europe, except Germany, has made a particularly rapid recovery since the end of hostilities. These conclusions are documented by the table on page 2. Even though some of the data are not complete, and boundary changes and other factors may obscure the actual trends, the available information provides a good basis for appraising the postwar public health picture.

In almost all the countries of Western Europe the death rates in 1946 and 1947 were about equal to or even below the prewar level. The postwar death rate in France is the lowest in her history. The record is very favorable also in England and Wales, the Netherlands, the Scandinavian countries, and Switzerland. If account is taken of the aging of the population in these countries, their death rates currently are lower than ever before. In Germany, on the other hand, the postwar death rate is above the prewar level.

For Central and Eastern Europe the reports are meager. Czechoslovakia's postwar mortality record is favorable. The published postwar figures for Austria, Rumania, and Hungary are at or below the prewar level, but because of doubts as to the reliability of the data, it may be concluded only that some degree of recovery has been achieved. Bulgaria, which was little affected by the war, shows no substantial change in the death rate during the war and postwar periods. No recent information is available for Poland, Yugoslavia, the U.S.S.R. or Greece.

The trend of tuberculosis, generally a sensitive index of health conditions, varies greatly in Europe. All-time low death rates from tuberculosis have been established in the postwar period in England, France, and Belgium. In the Scandinavian countries, there has been no increase in tuberculosis either during the war or after. In contrast, sizable increases, both in cases and in deaths, have been recorded throughout central Europe and the Balkans, according to a recent survey.* Fragmentary data for Italy show an increase for that country too. These

*HOLM, JOHANNES. "Tuberculosis in Europe after the Second World War." *The American Review of Tuberculosis*, Volume LVII—1948, No. 2, page 115.

MORTALITY DATA FOR SELECTED COUNTRIES OF EUROPE, 1943 TO 1947, COMPARED WITH PREWAR YEARS

YEAR	Austria	Belgium	Bulgaria	Czecho-slovakia	Den-mark	England & Wales	Finland	France	Ger-many	Hungary	Italy	Nether-lands	Norway	Portugal	Rumania	Sweden	Switzer-land
	DEATH RATES FROM ALL CAUSES PER 1,000 INHABITANTS																
1937-1939	14.2	13.4	13.6	13.2	10.4	12.0	13.6	15.6	11.9	14.1	13.9	8.6	10.2	15.5	19.0	11.7	11.6
1943	13.8	13.6	13.0	14.1	9.6	13.0	13.4	16.6	12.1	13.5	15.2	10.0	10.5	15.3	18.1	10.2	11.0
1944	16.0	15.9	13.7	*	10.2	12.7	18.1	19.8	*	15.4	15.9	11.8	10.0	14.8	19.6	10.8	12.0
1945	25.6	14.8	14.9	17.6	10.5	12.6	13.1	16.6	*	*	13.8	15.3	9.5	14.2	20.0	10.8	11.6
1946	13.4	13.6	13.7	13.7	10.3	11.5	11.7	13.3	12.4†	14.7	11.9	8.5	9.2	14.7	18.0	10.5	11.3
1947	12.5	13.1	*	11.9	9.6	12.0	9.0	13.0	*	12.3	11.4	8.0	9.3	13.3	*	10.9	11.2
	TUBERCULOSIS DEATH RATE PER 100,000 INHABITANTS																
			(a)	(b)				(c)		(d)	(e)		(f)				
1937-1939	100‡	69	155	127	40	65	198	161	52	118	124	45	88	149	169	81	83
1943	*	82	160	156	34	61	192	185	*	142	199	70	68	152	164	69	76
1944	118	82	148	170	33	57	192	151	*	138	236	75	74	145	*	67	81
1945	151	78	160	*	33	56	*	119	*	246	176	86	61	152	*	59	83
1946	101	66	161	*	32	53	*	78	65†	143	159	47	61	157	*	51	76
1947	84	*	*	*	*	*	*	72	65†	*	*	*	53	*	*	*	*
	INFANT MORTALITY PER 1,000 LIVE BIRTHS																
1937-1939	82	82	144	108	61	54	69	65	61	129	104	36	39	136	179	42	44
1943	79	75	130	109	45	49	49	75	*	116	113	40	35	133	172	29	40
1944	88	83	121	*	48	45	69	78	*	*	102	46	37	122	162	31	42
1945	162	100	145	138	48	46	63	108	*	*	99	80	36	115	188	30	41
1946	81	75	124	109	46	43	56	73	105†	114	84	39	*	121	164	26	39
1947	76	75	*	*	*	41	59	66	*	111	82	34	*	*	*	25	39

*Not available. †British Zone. ‡1937-1938. The Tuberculosis death rates in the columns designated by the following footnotes refer to specific cities, in the absence of data for the respective countries. (a) Large towns. (b) Prague. (c) Paris. (d) Budapest. (e) Rome. (f) Oslo.

Chief Sources: Publications of Statistical Office of the United Nations, the Epidemiological Information Service of the World Health Organization, and the United States Federal Security Agency.

reported increases are understandable in the light of the disorganization of antituberculosis programs, extreme crowding, malnutrition, and other adverse living conditions.

The postwar record for infant mortality—usually another sensitive index of health conditions — is remarkably good. This is particularly noteworthy because the sharp postwar increase in the birth rate in Europe, reported in the STATISTICAL BULLETIN of September 1947, has continued. In almost every country, infant mortality rates show a postwar recovery. This situation reflects the special provisions made for pregnant women and for infants by the Europeans themselves, and the efforts of outside nations which have favored these women and infants in their European relief programs. Record low infant mortality rates have been recorded since the war in England and Wales, Sweden and Denmark, among others. Sweden's record is outstanding, with a rate of only 26 per 1,000 live births in 1946, the lowest ever recorded for any European country. Germany, on the other hand, makes a comparatively poor showing. In the British zone, the infant mortality rate was 105 in 1946 and very little less in the American zone, as compared with the rate of about 60 in Germany as a whole in prewar years. The situation there seems to be improving, however. Despite the reduction in infant mortality rates in Europe, they still remain high in many parts of the Continent.

The war-caused disruption of sanitary services again brought the specter of typhoid fever and other enteric diseases to many countries. In 1945, when destruction reached its climax and government services collapsed in a large part of the Continent, typhoid fever got out of hand in several areas; in some it is not yet under control. Poland, Germany, and Austria still suffer severely. In Europe, outside of Russia, about 250,000 cases and 25,000 deaths from typhoid fever were reported in each of the last two years.

Diphtheria, which was one of the leading wartime epidemic diseases in Western Europe, is now receding, although it is still well above prewar levels. In England and Wales, however, diphtheria incidence and mortality fell during and after the war. Cases in 1947 were down more than 85 percent from the average for 1937-1939, and deaths were lower by more than 90 percent.

Typhus fever, which cost millions of lives in Eastern Europe during and after World War I and which threatened to become a major problem in the recent war, was checked even in wartime in the areas under the control of the Western military powers. There has been only a moderate rise in typhus incidence since the close of the war and this is limited to the usual endemic areas of the disease, such as Rumania, Bulgaria, and Hungary.

The relatively favorable health conditions in Europe today reflect in part the efforts of U.N.R.R.A.

Chief Sources: Publications of Statistical Office of the United Nations, the Epidemiological Information Service of the World Health Organization, and United States Federal Security Agency.

and other agencies. Our country has made major contributions by generous gifts of food and medical supplies, and by sending trained men to help restore sanitary and welfare services. Another factor in curbing sickness and death has been the application of new medical discoveries such as the sulfa drugs, penicillin, and D.D.T. The European nations helped themselves, too, by careful husbanding and distribution of their food resources. In addition, a most fortunate circumstance has been the virtual absence of any serious and widespread epidemic of respiratory diseases, such as the recurrent waves of influenza which swept Europe in 1918 and after. To some degree also the postwar recovery in European health reflects the weeding out of weaker persons who did not withstand the rigors of wartime living.

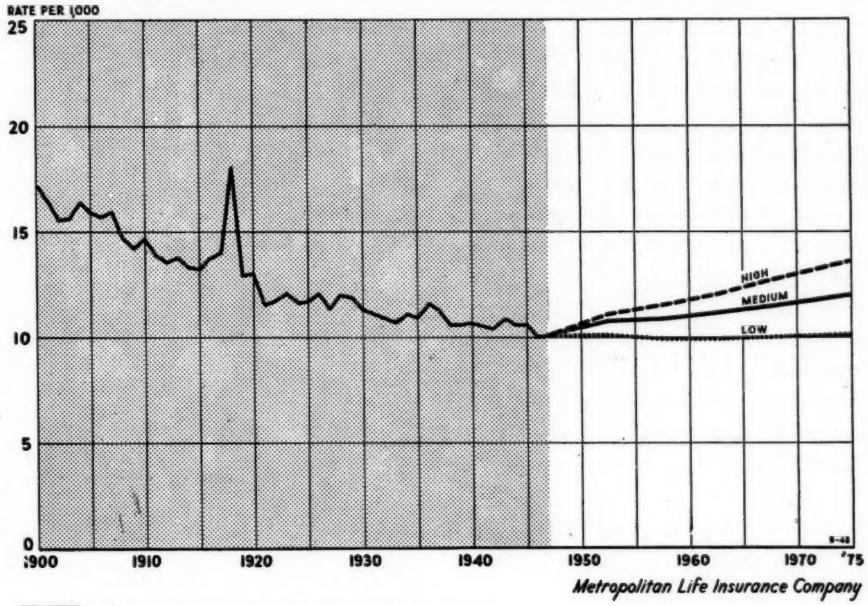
Despite the relatively favorable mortality picture in postwar Europe, much must be done to improve public health in most of the Continent. The inadequate diet and the low standards of living, if unrelieved, will remain a threat to the health of Europe. The program of aid upon which the United States is now embarked, will undoubtedly provide many of the necessities of life, including food, clothing, and medical equipment, which are now in very short supply. American aid will also enable the countries to rebuild their public health organizations; the guidance of the World Health Organization should prove of great help in this task. Large numbers of young physicians are studying at American and British medical institutions under W.H.O. auspices, and are preparing themselves for leadership in medical teaching and service in their respective countries. With these measures and with the application of the advances made in medical science and public health during the war years, there is reason for optimism with respect to the future health of Europe.

What Will Our Future Death Rates Be?

THE efforts to protect and conserve life in our country have been richly rewarded. Since the beginning of the century, the death rate in the United States has dropped more than 40 percent. In 1900, the rate was 17.2 per 1,000 population; by 1940 it was down to 10.7 per 1,000, and in 1947 about 10.1. The prospects are, moreover, that further improvement will be made in the death rate at every period of life, except the older ages. Yet it appears likely that the crude death rate at all ages combined will rise somewhat in future years. How is this paradox to be explained?

First, it should be noted that if the present death rate of about 10 per 1,000 continued, it would ultimately result in an average lifetime of 100 years. In the present state of our knowledge, to expect that the average person will live

CRUDE DEATH RATES IN THE UNITED STATES
Observed from 1900 to 1947;* Estimated from 1948 to 1975†



*For States in expanding Death Registration Area.
†Based on the mortality assumptions underlying the population estimates in *Forecasts of the Population of the United States, 1945-1975.* Bureau of the Census, 1947.

that long, would be to indulge in wishful thinking. Actually, the average length of life in the United States is now close to 67 years. In a stationary population, the death rate corresponding to this figure would be about 15 per 1,000, a figure half again that currently being experienced. The reason for the much more favorable death rate which now prevails, lies in the high proportion of people at the childhood and early adult ages, the periods of life when mortality is lowest. In time, this high proportion will diminish while the older ages will gain in relative importance. With this rise in average age, the high death rates of the later ages of life will assume increasing weight in the total mortality picture.

The illustration above shows the projections of the death rate to the year 1975, according to three assumptions of future mortality—low, medium, and high—utilized in a study of population forecasts recently issued by the Bureau of the Census.* On the basis of the least favorable assumption, that of "high" future mortality at the various age periods of life, the crude death rate

*WHELPTON, P. K. *Forecasts of the Population of the United States, 1945-1975.* U. S. Bureau of the Census, Washington, 1947.

for the population as a whole would rise to about 13.5 per 1,000 by 1975. It is obvious from the chart that even this rate would be well below the figures recorded at the beginning of this century. The "medium" assumption of future mortality is more likely to represent what will happen. According to this assumption, the death rate will rise very gradually to 11 per 1,000 around 1960 and further to 12 by 1975. On the basis of the most favorable assumption, i.e., of "low" future mortality, the death rate would first decline slightly and then return to its present level. To translate this goal into reality would require much greater success in controlling the mortality at the older ages than has been achieved in the past.

Whichever course the future death rate will take, the average length of life will undoubtedly continue to increase as further progress is made in life conservation. The explanation for this lies in the fact that the average length of life, unlike the crude death rate, is not affected by the prevailing age distribution of the population. Estimates of future longevity are not available for the population as a whole; such forecasts which have been made for native white males on the basis of the mortality assumptions referred to above, are shown in the accompanying table. The figures indicate that average length of life among native white males may increase by about three years between 1940-1944 and 1975 on the assumption of "high" mortality, and by 4½ years and by more than seven years on the assumptions of "medium" and "low" mortality, respectively.

The outlook is bright indeed for increasing further the longevity of the American people. The far-reaching advances of medical science and public health administration, which have already drastically reduced infant mortality, tuberculosis, pneumonia, and other diseases, will continue to make gains. In addition, new methods of disease prevention and treatment are being developed. Altogether, the future holds great promise of health achievement.

AVERAGE FUTURE LIFETIME EXPECTED FOR NATIVE WHITE MALES IN THE UNITED STATES

EXACT AGE	1929-1930	1939-1940	1940-1944	HIGH MORTALITY ASSUMPTIONS		MEDIUM MORTALITY ASSUMPTIONS		LOW MORTALITY ASSUMPTIONS	
				1960	1975	1960	1975	1960	1975
Birth	58.8	62.6	63.3	65.6	66.0	66.6	67.8	68.2	70.6
20 years	45.9	47.6	47.9	48.9	49.0	49.8	50.5	51.4	53.1
40 years	29.2	29.9	30.1	30.5	30.6	31.3	31.8	32.9	34.3
60 years	14.5	14.9	15.0	15.0	15.0	15.2	15.3	16.3	17.0

Source—WHELPTON, P. K. *Forecasts of the Population of the United States, 1945-1975.* Page 13. U. S. Bureau of the Census, Washington, 1947.

Orthopedic Impairments Among Children

THERE are about 400,000 children and young people under age 21 in the United States who are more or less seriously handicapped by orthopedic impairments. This is the number recorded in the State registers of crippled children, and undoubtedly understates the number actually afflicted.

Poliomyelitis is the leading cause of orthopedic impairment among young people, accounting for one fifth of the handicapped under 21. Second in rank is cerebral palsy, a condition which has received little attention in our country until recent years. Most communities have failed to recognize the magnitude of the problem, or to provide even a minimum of services for children with this disease. This is unfortunate, because with proper methods of treatment, education, and physical rehabilitation, about one half of the victims can be helped to attain economic self-support and general social adjustment. It is encouraging to note, however, that studies are now under way to determine the best ways of preventing and treating the condition.

Much more favorable is the outlook for a number of the other impairments which result from prenatal influences and injuries at birth. Clubfoot, Erb's palsy (paralysis due to birth injury), dislocations, and torticollis (wry neck), for example, can be cured or their residual effects greatly minimized, particularly if treatment is begun early in life. Moreover, if treatment is neglected in some conditions, as in congenital dislocations of the hip, the disability is apt to increase with advance in age.

Trauma and osteomyelitis are also among the leading causes of orthopedic handicaps, as may be seen from the chart on page 8. While they are less prevalent than poliomyelitis or cerebral palsy, they nevertheless are responsible for many cases of severe crippling.

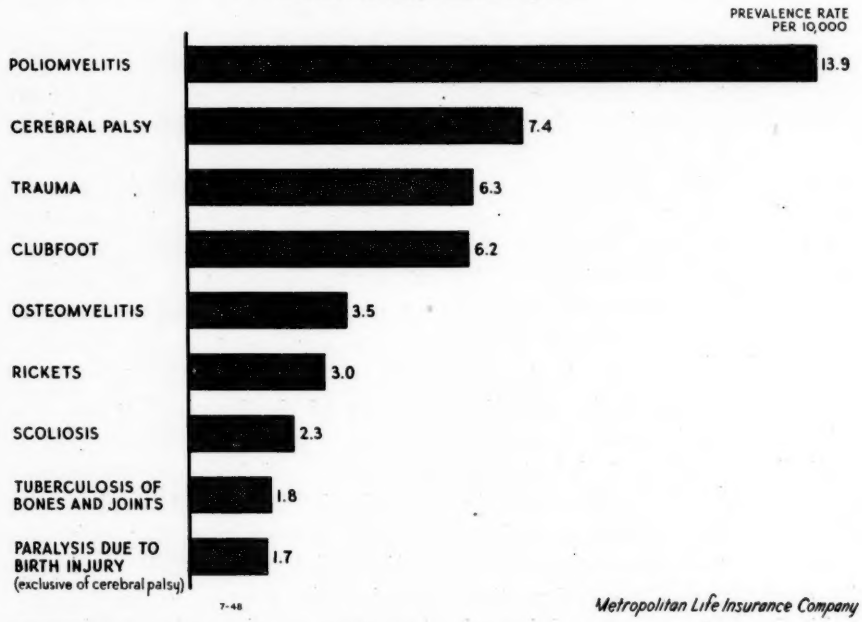
The relative frequency of the various orthopedic impairments varies from age to age. As one would expect, congenital defects and birth injuries are responsible for the majority of orthopedic handicaps in the early years of life—more than three fifths of the total at ages under 5. Acquired defects, on the other hand, are numerically the more important at the older ages. These facts are apparent from the figures in the table on page 9. Clubfoot, for example, is the major cause of impairment at ages under 5, and is responsible for 22 percent of the total at those ages. Its relative importance, however, declines with age, and it accounts for only 4 percent of the impaired at age 20. Traumas, in contrast, account for 3 percent of all impairments among preschool children, but for about 13 percent among young people at their majority. Similarly, each of the infections especially osteomyelitis, tuberculosis, and arthritis, accounts for a greater proportion of

crippled children in each successive age period. It is apparent from the table that poliomyelitis leads every other orthopedic impairment in frequency beginning with the school ages.

Since the turn of the century, remarkable progress has been made in the prevention of diseases which cause physical impairments. Tuberculosis of the bones and joints, which was a prominent cause of disability only a generation ago, has decreased markedly in frequency and now accounts for less than 3 percent of all orthopedic defects among children under 21 years. Similarly, the prevalence of rickets has been diminishing rapidly, as the standard of living has been raised and as the science of nutrition has advanced. Further progress in prevention may be expected from increased control over the infectious diseases, from improved obstetrical practices, and from the intensive research into the role of diet during pregnancy. Improvements in traffic control and wider safety education should lead to a reduction in crippling due to accidents.

Each year many thousands of children are born malformed or become crippled through disease or injury. Greater attention needs to be focused on minimizing the extent of

LEADING CAUSES OF ORTHOPEDIC IMPAIRMENTS AMONG CHILDREN UNDER AGE 21 UNITED STATES,* JANUARY 1, 1945



*Excludes Delaware, Montana, Pennsylvania, and Virginia.

Source—Crippled children on State registers, reported to U. S. Children's Bureau

RELATIVE FREQUENCY OF ORTHOPEDIC IMPAIRMENTS AMONG CHILDREN BY SPECIFIED AGE PERIODS UNDER 21, UNITED STATES,* JANUARY 1, 1945

IMPAIRMENT	PERCENT DISTRIBUTION IN EACH AGE PERIOD					
	0-20	0-4	5-9	10-14	15-19	20
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0
Poliomyelitis	20.0	12.3	20.7	21.3	21.6	20.6
Cerebral palsy	10.7	8.4	12.8	12.0	9.6	8.7
Trauma	9.1	3.0	7.1	10.2	11.7	12.8
Clubfoot	9.0	22.3	11.7	6.8	4.1	3.8
Osteomyelitis	5.1	1.3	2.9	5.7	7.2	7.9
Rickets	4.4	7.4	7.5	3.6	2.0	1.4
Scoliosis	3.3	.5	1.1	2.9	6.0	7.2
Tuberculosis of bones and joints	2.7	.7	1.9	3.0	3.5	4.2
Paralysis due to birth injury (Exclusive of cerebral palsy)	2.4	3.5	2.6	2.2	2.0	2.4
Epiphyseal disturbances	2.2	.3	1.4	2.8	3.1	2.7
Congenital dislocation of hip	2.2	1.8	2.2	2.3	2.3	2.2
Arthritis	2.1	.5	1.2	2.2	3.1	3.9
Spina bifida	1.5	4.2	1.5	1.1	.8	.6
Torticollis	1.3	1.5	1.4	1.3	1.1	1.0
Muscular atrophy or dystrophy	1.1	.3	.8	1.4	1.3	1.4
"Other congenital defects"	8.4	19.3	9.3	6.5	5.2	5.5
All other definite diagnoses	14.5	12.7	13.9	14.7	15.4	13.7

*Excludes Delaware, Montana, Pennsylvania, and Virginia.
Source—Crippled children on State registers, reported to U. S. Children's Bureau.

residual damage among these children. Much has already been accomplished in this field by the U. S. Children's Bureau, the National Foundation for Infantile Paralysis, the National Society for Crippled Children and Adults, and by other official and voluntary organizations. Both economic and humanitarian considerations require that orthopedically handicapped children be given adequate treatment and training. This would enable them to make their contribution to our economic life and become useful members of society.

Malaria Being Wiped Out

THE intensified campaign against malaria carried on in our country during and after World War II, has been eminently successful. In 1941, there were 68,075 cases of the disease reported in the United States; by 1947, the number of new cases had dropped to 17,317, a reduction of 75 percent in only six years. The record is even more favorable if we exclude the cases among our armed forces brought in from abroad.

The decline in new cases nationally is accounted for by the sharp reduction in some of the southern

States, where the malaria problem has long been concentrated. As is evident from the accompanying table, the East South Central States, which were responsible for more than three fifths of all the new cases in the country just before the war, showed a decrease of more than 90 percent between 1941 and 1947. The outstanding record for this geographic division reflects very largely the experience in Mississippi, where new cases in this period dropped from 36,845 to 914, or almost 98 percent. In the West South Central and in the South Atlantic States, the number of cases was reduced by almost one half.

The increased incidence of malaria in the other areas of the country during and immediately after the war, represents largely cases contracted outside the United States. Large numbers of our armed forces, it will be recalled, served in some of the worst infected areas of the world, including the South Pacific, India, Italy, North Africa and the Near East. It was generally feared that the military personnel returning from these places might introduce the disease in the large malaria-free areas of our country. This situation, fortunately, has not materialized, undoubtedly because of the vigilance of the U. S. Public Health Service and local health departments.

Malaria can be virtually eradicated in our country within a relatively short time. This can be accomplished through the more extensive use of modern methods, particularly D.D.T. spraying, which have already proved effective in mosquito control. Even after the disease is eliminated here, the health authorities must be ever alert to the dangers of malaria vectors being brought in by planes and ships from other parts of the world where the disease is endemic.

MALARIA CASES REPORTED IN UNITED STATES, 1941 TO 1947

GEOGRAPHIC DIVISION	1947	1946	1945	1944	1943	1942	1941
UNITED STATES—TOTAL	17,317	47,916	62,763	57,629	54,555	60,071	68,075
New England	231	1,261	1,547	907	149	25	30
Middle Atlantic	478	2,994	3,335	1,502	148	131	101
East North Central	491	2,695	1,945	939	747	121	196
West North Central	581	1,874	2,207	639	217	91	108
South Atlantic	5,371	8,083	13,762	12,038	10,938	11,487	11,438
East South Central	2,808	19,645	23,041	26,871	28,655	36,359	42,204
West South Central	7,007	9,396	13,662	12,377	11,175	11,593	13,705
Mountain	157	638	1,293	314	456	65	82
Pacific	193	1,330	1,971	2,042	2,070	199	211

CRUDE DEATH RATES* PER 100,000 POLICYHOLDERS FROM SELECTED CAUSES
INDUSTRIAL PREMIUM-PAYING BUSINESS—*Weekly and Monthly Combined.*
METROPOLITAN LIFE INSURANCE COMPANY

APRIL 1948

CAUSE OF DEATH	ANNUAL RATE PER 100,000 POLICYHOLDERS*				
	April 1948	April 1947	YEAR TO DATE: END OF APRIL		
			1948	1947	1946
ALL CAUSES—TOTAL	694.9	720.8	715.7	712.5	789.1
—Excluding war deaths	*694.8*	*720.0*	*715.6*	*711.6*	*763.7*
Typhoid fever	0.2	0.2	0.1	0.2	0.1
Measles	.9	.3	.7	.3	.9
Scarlet fever	.1	.1	.1	.1	.2
Whooping cough	.4	.5	.5	.6	.8
Diphtheria	.1	.7	.3	.8	.7
Influenza	1.9	8.3	2.9	4.8	9.3
Pneumonia (all forms)	24.5	35.5	29.4	30.8	36.0
Tuberculosis (all forms)	29.5	29.4	28.5	31.7	37.0
Tuberculosis of respiratory system	26.5	26.9	25.9	28.8	33.6
Syphilis	6.8	7.2	7.1	7.7	8.1
Acute poliomyelitis	.1	.1	.1	.4	.2
Cancer (all forms)	110.6	107.0	112.3	109.1	107.2
Diabetes mellitus	25.2	23.2	25.5	23.8	28.4
Principal chronic cardiovascular-renal diseases	327.4	336.8	348.4	337.5	352.5
Cerebral hemorrhage	61.8	66.2	65.2	65.3	67.6
Diseases of the coronary arteries and angina pectoris	73.8	71.1	83.4	74.9	70.9
Other chronic heart diseases†	155.0	161.7	162.2	158.1	171.0
Chronic nephritis	36.8	37.8	37.6	39.2	43.0
Diarrhea and enteritis	2.7	4.5	3.3	3.7	2.7
Appendicitis	2.9	2.2	2.5	2.6	3.8
Puerperal state—total	2.6	3.3	2.5	3.3	3.1
Suicides	7.2	6.7	6.6	6.6	7.5
Homicides	3.8	2.6	3.2	2.9	3.5
Accidents—total	39.4	39.9	38.8	40.5	49.5
Home accidents	10.0	9.6	11.5	11.2	11.8
Occupational accidents	3.4	5.4	4.1	4.8	4.4
Motor vehicle accidents	11.0	11.9	11.9	14.0	15.7
War deaths (enemy action)	.1	.8	.1	.9	25.4
All other causes of death	108.4	111.3	102.7	104.3	112.3

*The rates for 1948 and 1947 are subject to slight correction, since they are based on provisional estimates of lives exposed to risk.

†International List (1940) titles 92, 93 (c), (d), (e), and 95.

NOTE—The death rates in this table differ from the rates previously published on the basis of the Weekly Premium-Paying Business alone.

Correspondence on the subjects discussed in these BULLETINS may be addressed to:

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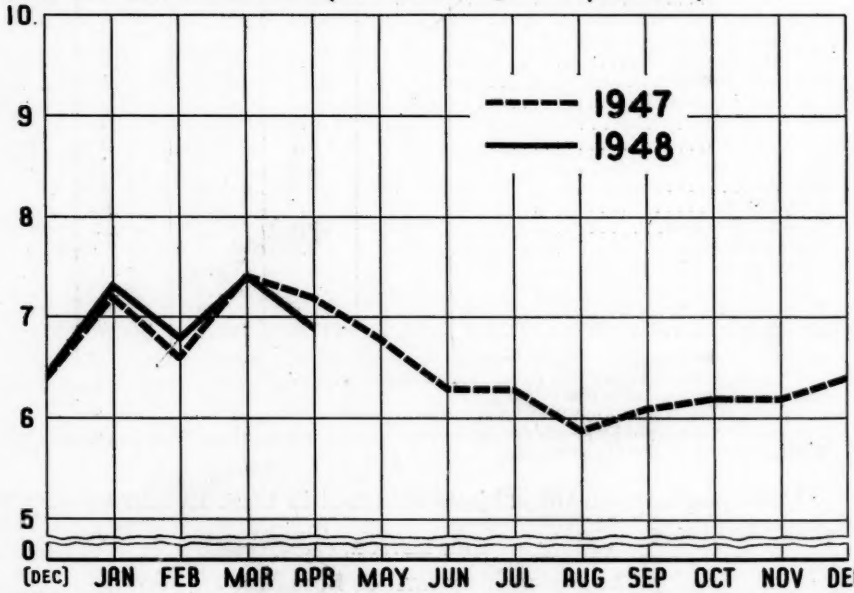
MORTALITY FROM ALL CAUSES

METROPOLITAN LIFE INSURANCE COMPANY · INDUSTRIAL PREMIUM-PAYING BUSINESS
WEEKLY AND MONTHLY COMBINED

DEATH RATES PER 1,000 · ANNUAL BASIS (*1947 and 1948 figures are provisional*)



	(DEC)	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
1947		7.2	6.6	7.4	7.2	6.8	6.3	6.3	5.9	6.1	6.2	6.2	6.4
1948		7.3	6.8	7.4	6.9								

Note—The death rates in this chart differ from the rates previously published on the basis of the Weekly Premium-Paying Business alone.

P F.M.—(5-48)—PRINTED IN U.S.A.